

NOBLE (C.P.)

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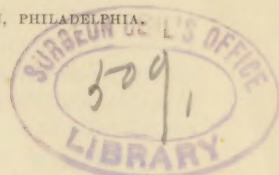
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A NEW METHOD OF EXAMINING THE KIDNEY, ESPECIALLY FOR STONE.

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I DESIRE to report a short history of the following case, together with an exploratory operation which I performed to enable me to examine her kidney, including the pelvis of the kidney and perhaps one inch of the ureter.

Mrs. T. S., aged thirty-seven years, mother of three children, enjoyed good health until six years ago. Since that time she has been more or less an invalid, and for the past six months she has been absolutely an invalid, unable to attend to her duties. The prominent points in the history are that she has had three well-marked attacks of hæmaturia accompanied by violent renal colic (so called), and that at least twice she has passed good-sized stones, the last one coming from the left kidney. In addition to this history of violent seizures of renal colic, she has suffered frequently with milder attacks of paroxysmal pain referred to the region of the right groin, the pain being, perhaps, most acute just above the right trochanter major. Recently these attacks have been of daily occurrence, and have been brought on when she was on her feet. She is usually, but not always, comfortable when in bed, but shortly after any attempts at walking the pains come on. The sexual organs are normal, with the exception of a trifling tear in the perineum. The urine has been examined many times and has a very uniform composition. Its specific gravity has varied between 1020, 1013, and 1018; it is acid, and contains pus, bladder epithelium, and ureteral epithelium, but none from the pelvis of the kidney. The urine from each kidney has been examined separately, being obtained by means of the ureteral catheter. Examined in this way it has been found that the urine from each kidney is much the same, the pathological elements it contains being somewhat more marked on the right side. This difference, however, was distinctly marked with reference to the two sides: the urine from the left kidney has always flowed through the ureteral catheter freely and regularly; that from the right kidney has not done so. Upon two occasions the ureteral catheter remained in position upward of twenty minutes, and not more than one or two drops of urine flowed out. Upon another occasion, after waiting thirty minutes with the same result, suddenly one hundred and twenty minims poured out.

Taking all the facts of the case into consideration the conclusion seemed fair that there was a stone in the right ureter, and that probably this was in the pelvis of the right kidney. Several attempts were made, both by Dr. Howard A. Kelly and myself, to pass a ureteral sound along the ureter toward the kidney. It was not possible to make the sound reach above the brim of the pelvis. It was therefore proposed that an incision be made in the loin for the purpose of examining the kidney and the upper portion of the ureter from above.

My experience in performing nephrorrhaphy for movable kidney after the technique of Dr. Edebohls, has taught me the facility with which *a movable kidney* can be drawn out through an incision in the loin. So far as I know, no one has ever treated a non-movable kidney in this way. It occurred to me that this might be feasible, and that at all events an attempt judiciously made could hardly be a source of danger.

Accordingly on December 12th, I made the usual incision in the loin down to and through the peri-renal fat, exposing the lower end of the kidney. With the index finger the kidney was then separated from its connective-tissue attachments and gradually drawn down into and out through the wound, so that it was entirely outside. It was now a very simple matter to explore the kidney by thumb-and-finger pressure, and to make certain that it was in a normal condition. It was equally easy to examine the pelvis of the kidney and to determine that this contained no stone. Perhaps one inch of the ureter also was within reach.

As nothing abnormal could be felt, the kidney was replaced within the abdomen and the incision was sutured in the usual way—buried silkworm-gut sutures being placed in the muscular layer, and superficial silkworm-gut sutures in the skin. No unfavorable reaction followed this operation, and so far as the operation itself was concerned the patient made an uninterrupted recovery. Unfortunately the operation has produced no effect whatever on the symptoms, which are the same now as before it was done.

I report the case simply to bring before you this method of examining the kidney. From my experience in this case and in cases of movable kidney, I believe it will be a simple and safe matter in the hands of a skilful surgeon, who has had some experience in kidney work, to remove through an incision in the loin all non-suppurating kidneys having approximately the normal size, for the purpose of a careful examination. The procedure is certainly not one of much gravity, and when done under the conditions laid down should have no mortality. Tentatively I would recommend the adoption of this method of exploring the kidney whenever the symptoms point to the presence of stone in the kidney or its pelvis, and when these symptoms are of sufficient gravity to invalid the patient. I feel confident that as compared with the ordinary method of exploring the kidney through the depths of the incision in the loin, the kidney itself being largely or wholly above the level of the ribs, and imperfectly palpated

because of its movability, or examined by means of a puncture with an exploring needle, that there can be no question of the superiority of the method proposed and herewith reported.

Upon theoretical grounds this procedure would not be applicable in cases of abscess of the kidney. Under these conditions, supposedly the kidney would be fixed and not easily separated from its connective-tissue bed. Moreover, it would be enlarged, and in addition to this there would be the risk of rupturing the pus sac, perhaps inadvertently into the peritoneal cavity.



